ASSOCIATION of MIDWIVES of NEWFOUNDLAND & LABRADOR

Newsletter No. 30, June 2004

Association of Midwives of Newfoundland and Labrador
(Chapters in Goose Bay and St. John's)
Newsletter 30
June 2004

MISSION STATEMENT

To provide professional information for midwives, and to promote the recognition of the role of midwives, and the need for appropriate legislation so that midwives in Newfoundland and Labrador are publicly funded to legally provide research-based, total midwifery care as a choice for childbearing families in this province.

This Newsletter contains a summary of the Annual General Meeting held on March 30, 2004. There are other items of interest to members. The annual membership fees were due on January 1. If you have not yet paid please send your fees to the Treasurer as soon as possible. There is a membership form at the end of this Newsletter.

This Newsletter is the method by which members are kept informed about midwifery and other maternity matters. Send items and constructive comments to the President for forwarding to the Editor. Thank you for items contributed. Those who submit are responsible for obtaining permission to publish in our Newsletter. The Editor does not accept this responsibility.

Pearl Herbert, Editor.

AMNL General Meetings,
Tuesday, September 21, 2004 (tentative), 4:00 p.m. (Island time)
and Tuesday, January 11, 2005 (tentative), 4:00 p.m. (Island time)
The meeting in St. John's will be at Telemedicine, HSC. All sites wishing to be connected need to provide their telephone number to TETRA Telemedicine (1-877-737-0281) prior to the meeting. (For reporting problems during the meeting call 709-737-6654.)

Executive Committee

President: Karene Tweedie, CNS, 100 Forest Road, St. John's, NL, A1A 1E5
Treasurer: Pamela Browne — Secretary: Kay Matthews
Past President: Ann Chaulk — Newsletter Editor: Pearl Herbert
Home page: http://www.ucs.mun.ca/~pherbert/ — Newsletter in HSLibrary: WQ 160 N457n

Summary of the Annual General Meeting held on March 30, 2004, at 4:00 p.m.

There were seven members present. Some amendments were made to the January minutes, mostly with regarding to the Health Care Transitional Funding for which Not Yet Regulated jurisdictions do not qualify. Karene Tweedie gave the President's report which is printed below. Pearl Herbert reported that the January Newsletters had been distributed electronically in pdf format but not all members could assess this. It was decided to send members paper copies unless they specifically requested an electronic copy. The Newsletter will be sent electronically to those on the distribution list who are not AMNL members. (The Newsletter report was included in the March Newsletter.)

Karen Robb reported that the video will not be completed until the end of September. Karen is moving to Nova Scotia so Pamela Browne offered to help with the financial accounts, and Kelly Monaghan offered to take over the supervision of the video project.

Karene Tweedie reported on the Vision/Lobbying Activities, and distributed a list of the activities which have been carried out over the years, which she had gleaned from old AMNL records. Karen Robb and Kelly Monaghan have been writing letters to newspapers. The two AMNL Chapters met on February 2 and March 29 by telephone calls to discuss these activities. Advice was received regarding the old Midwives Act, which has been amended over the years as other Acts have been passed which impinged on this Act. There are benefits to having a Midwives Act as it acknowledges that there is such a profession, and both the Nurses Act and the Medical Act cannot prevent or take over midwifery. Kelly will make available a written summary of this discussion to AMNL members.

President's Report 2004

This is my first report as President of AMNL. I wish I could say that our membership has soared to 50 and that we are excited that we have at last achieved legislation, but unfortunately neither is the case! Since the last AGM on April 15, 2003, there have been two meetings, one on September 16, 2003 that 10 members attended and another on January 13, 2004 which 5 attended. This is thanks to the donating organizations that enable us to hold these meetings by teleconference.

There were four newsletters in the last year thanks to the hard work and dedication of Pearl Herbert. It was hoped that the newsletter could be distributed more cost effectively by e-mail and this was tried. Unfortunately, not everyone could access it by this route and so this matter warrants further consideration. Pearl has included her Newsletter Report in last month's newsletter (March 2004). The newsletter continues to be an important source of information for midwives and maternity nurses in the province. It also helps to connect members who are separated by great distances both within the province and outside the country.

In efforts to extend communication further, the web site is kept updated by Pearl. Individuals and organizations visit the web site quite frequently seeking information about midwifery and the AMNL. The web site also helps to put people in touch with us by phone and e- mail. We receive quite a lot of requests for information from students who are writing papers on midwifery, not only in this province but also in others. This is very encouraging. We also receive some queries from individuals who want to pursue midwifery education.

Ann Chaulk continued to act as CAM representative until October then Kay Matthews took her place. Ann attended the CAM AGM and conference October 01-03, 2003 and also participated in a strategic planning day on September 30th to address the need for a national risk management program. Thank you Ann for all the work you did for AMNL with regards to CAM. Karen Robb was invited to attend and presented on the challenges she faces as a midwife with a practice in St. John's. Thanks to Kay for taking over the CAM responsibilities. Kay has also become AMNL's representative on the recently formed Not Yet Regulated Committee (NYRC). Jean Hunt, treasurer, left the province in the spring and Pamela kindly volunteered to take the position once again. Thanks Pamela.

Membership continues to be a challenge. At times we have had more than twice our current membership in the AMNL. While the increase in fees to $75 to maintain our membership with the Canadian Association of Midwives has taken its toll, most of the

membership believes it is both important and beneficial to be part of the national association. However, some midwives don't see the point of paying $75 when they can't even practice their profession. This is unfortunate but understandable. There have been many membership drives over the years, but despite this numbers are low and there are no members in St. Anthony. I hope to rectify this but we have to ask ourselves, " What do people get for their $75?" This is something that AMNL needs to consider. What can we do to encourage more midwives to join? How can we justify to them that it is both in their interests to join as well as in the interests of the NL public?

While we all became despondent after coming so close to legislation in 2001, we can't give up the fight. However, at times it is difficult to keep giving so much of our time to a cause that seems beyond our reach. In April 2003 a complaint was lodged with Fraser March, Citizen's Representative by AMNL members who were appointed to the Provincial Midwifery Implementation Committee (MIC). The complaint focused on the waste of participants' time over a two-year period. This was time given on a voluntary basis on the understanding that legislation would be forth coming. Concerns were also identified about the lack of a Final Report. So far the complaint has not been addressed.

Karen was very active lobbying for midwifery around the time of the election. As usual candidates made promises that they have failed to keep! In particular Ross Wiseman, then Opposition Health Critic, promised that if the PCs won the election then he would reconvene the MIC and ensure that a Final Report was completed. We are still waiting! Other lobbying efforts were made by other members of AMNL and by Kelly Monaghan, coordinator of the Friends of Midwifery advocacy group. Lobbying for midwifery legislation has been very long standing. I have just completed a summary of lobbying activities over the years and it is discouraging that so much effort has essentially achieved very little.

It was hoped that our video, designed to promote midwifery in this province, would have been completed by now. However, there have been several delays primarily because the main actress has not been available. John Hong has been very giving of his time for this project and his involvement has been invaluable. Karen has been heavily involved and Pamela has also provided a lot of input. Friends of Midwifery also held a dinner in July and raised $542 for the project. It is, therefore, essential that this project be brought to fruition as soon as possible so that the video can be used to promote midwifery to professionals and the public in this province. This needs to be a priority.

A new advocacy group, Friends of Midwifery NL, was established in April 2003. There was initial interest in this from a number of individuals and organizations and it looked promising that lots of lobbying activities would be generated. Kelly Monaghan agreed to coordinate the group and operate an e-mail listserve. Unfortunately, the initial enthusiasm of many of the group members did not translate into action and only Kelly and one or two others have been active. Kelly receives little response to her e-mails, which must be disheartening. The thrust for legislation and midwifery services must come from the public and they must pressure the government to make midwifery an option for women and families in this province. Consideration needs to be given to the area of lobbying and promotion in order to make it more effective.

Christine Saulnier, Senior Research Officer with the Atlantic Centre of Excellence for Women's Health in Halifax initiated and coordinated meetings with midwives, Friends of Midwifery representatives, government and stakeholders, in an effort to move midwifery legislation forward in this province. A preliminary meeting was held on September 24th for

midwives and Friends of Midwifery and the main meeting was held the following day. Jane Helleur, private consultant facilitated the meetings and did an excellent job of keeping everyone on track. A report of the September 25th meeting was written and distributed by Christine that included recommendations. The essence of discussions at the meeting received mixed interpretation by AMNL members regarding their perceived sense of commitment to midwifery by the stakeholders. No matter what the interpretation, though, work needs to be done to convince government, health professionals, the public and other stakeholders that midwifery care should be available and accessible in this province.

Although I was unable to attend all of both meetings it was very evident to me that we need to have a clear vision of midwifery for this province. We have been committed to striving for legislation for autonomous funded midwifery but haven't given much consideration to specifics. Jane Helleur also recognized that a lack of vision was evident from the discussions. As a result I asked membership to share their vision of midwifery in this province and their ideas of how we might be able to reach our goals. Responses indicated that we do need to collaborate on developing a clear vision. To this end there have now been two meetings held for midwives (not necessarily AMNL members) and Friends of Midwifery to address the recommendations from the ACEWH meetings, to clarify our vision and to develop strategies for moving forward. I would like to commend members for their commitment to this association. We all lead busy lives and have many roles to play at times that can be very stressful. The easy option is to drop out and commit our time beyond work to activities that are relaxing or at least rewarding! It is a much more challenging option to continue striving to optimize health care for women, babies and families by promoting midwifery care and practice in this province. I think we need to congratulate ourselves for our tenacity and all our volunteer work. Thanks to all of you.
Respectfully submitted,
Karene Tweedie (President AMNL)

Some Happenings Around the Country

Quebec

From the SOGC June 2004 NEWSLETTER:

Midwives to assist with at-home births in Québec. A few months after allowing midwives to perform deliveries in Québec hospitals, Health Minister Philippe Couillard has announced that the government will allow midwives to assist with home births.

Expectant mothers have been able to get help from a midwife for more than a decade in Québec but the births could only take place in hospitals and birthing centres. Raymonde Gagnon, the president of the province's professional order of midwives, applauded the news, saying that parents have the choice to give birth where they feel most comfortable.

The new regulations take into account safety concerns raised by physicians over the years. Regulations will state that midwives have to ensure the home is safe, at a reasonable distance from a hospital and easily accessible to ambulances. Midwives must also establish relations with a physician in cases where a transfer to a hospital may become necessary.

SOGC's March 2003 Policy Statement on Midwifery (PDF document) recognizes and stresses the importance of choice for women and their families in the birthing process. All women should receive information about the risks and benefits of their chosen place for giving birth, and should understand any identified limitation of care at their planned birth setting. The SOGC endorses evidence-based practice and encourages ongoing research into the safe environment of all birth settings.

Ontario

Betty-Anne Daviss (Ottawa midwife) received the Y's "Women of Distinction" Award. When accepting the Women of Distinction award Thursday night, April 29, night Betty-Anne stated that she accepted "this award on behalf of the midwives, doulas, and our wonderfully active consumer group here in Ottawa --and the midwives and doulas around the world -- who help women in our overly technocratic world, to remember and understand what normal pregnancy and birth are." Other midwives who have received the award include: Anessa Maize (Winnipeg), Gloria Lemay (Vancouver), after which YWCA initiated a review process for nominations. Bobbie Soderstrom (Ottawa) late 1990s, Luba Lyons Richardson (Victoria) in 1998, Jane Blackmore (Creston, BC) in 2003.

Nova Scotia

"A proposal is to open a birthing Centre to be staffed by a collaborative maternity care team which is to include midwives. It is to be located in the North End Clinic in Halifax. The funding is to come from the Primary Health Care Transition Funds. At the same time as this proposal is going in, the provincial government has just set up a Provincial Working Group on Primary Maternity Care. The mandate of the group is to make recommendations for the development of a regulatory framework for midwifery for NS. It has its first meeting May 5th. Certification, registration and other regulatory questions are to be answered through the provincial working group. The project at the clinic is to be an implementation project. We hope that other project proposals will be going forward. How all of this will actually unfold is not clear. I think it is fair to say that those who have been working on this issue for many, many years, and who have seen advancements like this made before are all guarded in their optimism about what might happen, but are enthused to see something concrete going forward." Christine Saulnier, PhD Senior Research Officer, Atlantic Centre of Excellence for Women's Health

"Is the DoH looking to create some enabling mechanism to introduce only a few midwives in collaborative primary care "projects" (a.k.a. the process used for clinical nurse practitioners), or a broader legislative act? What does "inclusion of midwives in collaborative teams" mean exactly? How is home birth going to fit in this picture?" "Any regulation or regulatory process in NS has to be consistent with the basic parameters of midwifery in the rest of Canada (MRA requirements, direct entry, an equitable process for assessing and accrediting midwives, continuity of care, choice of birth place, etc...). The most essential thing right now however is defining and clarifying among ourselves the model(s) of midwifery we want to live with, and the political strategies we need to take." Kerstin Martin, Midwife, MNSA.

"We need to ensure that there is a liaison between the Canadian Midwifery Regulators Consortium and any midwifery planning in Atlantic Canada." Kim Campbell, President, CAM.

Nunavut

In May a couple from Kugluktuk gave birth in Edmonton to three baby girls. The triplets are the first to be born in Nunavut. Ten years ago, a set of triplets was born in Sanikiluaq, then part of the Northwest Territories [www.nunatsiaqnews.com May 28, 2004].

SOGC Press Release Friday, April 23, 2004

Obstetrical crisis identified in CIHI report no surprise to SOGC www.sogc.org

Ottawa - For the past number of years the Society of Obstetricians and Gynaecologists of Canada (SOGC) has been citing concerns to the Canadian government of the current obstetrical crisis in this country. In 2002, SOGC appeared before the Romanow Commission and clearly stated that the sustainability of human resources was an important issue. Contributing factors to this trend were the decline in the number of family physicians performing deliveries; lifestyle issues and medico-legal considerations. Furthermore, an SOGC survey has shown that over 1/3 of OB/GYNs plan to retire within the next 5 years, contributing to a looming shortage of obstetrical specialists.

The SOGC is currently working in close collaboration with key stakeholders directly involved in the provision of primary maternity care, including the Canadian Association of Midwives (CAM), the College of Family Physicians of Canada (CFPC), the Society of Rural Physicians of Canada (SRPC), and the Canadian Section of Association of Women's Health, Obstetrical and Neonatal Nurses (AWHONN). We are committed to finding solutions to the current maternity care crisis in Canada and, more specifically, to reducing the barriers that currently exist in the provision of multidisciplinary collaborative primary maternity care.

The CIHI report has also focused on the current rate of caesarean sections highlighting various factors influencing this outcome. The Society has always promoted natural childbirth and believes that the decision to perform a caesarean section should be based on medical indications. The SOGC along with other health care providers such as nurses and midwives have made a strong recommendation that women during labour and delivery be accompanied by a trained health care professional and that adequate resources be given to hospitals to fulfill our pledge to offer continuous support during labour and delivery.

The SOGC strongly believes that every woman should have equitable access to optimal, comprehensive health care provided with integrity and compassion. The Society wishes to reassure Canadian women and reiterate its commitment to continue to work with government, hospitals and other health care professionals to find viable solutions to the current obstetrical crisis in Canada.

Information: Andrée Poirier, Director of Communication and Public Relations
Tel: (613) 730-4192 extension 230 E-mail: apoirier@sogc.com Web site: www.sogc.org

Changes at International Confederation of Midwives (ICM)

Petra ten Hoope-Bender resigned as the Secretary General of ICM at the end of last year. The new Secretary General is Kathy Herschderfer who originates from Connecticut, and trained to be a midwife in Holland, where she now resides.

Petra ten Hoope-Bender has been appointed to the role of Executive Officer of the Partnership for Safe Motherhood and Newborn Health, which is co-chaired by the World Bank and ICM, and is based in Geneva. She took office at the end of February. This Partnership aims to promote the survival and well-being of women and newborns, especially those most vulnerable - so that all women, families, and communities enjoy rights to and resources for safe pregnancy outcomes. Web site: www.safemotherhood.org.

New free CD-ROM: Safe Motherhood Strategies: A review of the evidence. (2004). *International Midwifery, 17*(2), 22. [The European Commission commissioned 19 scientific background papers which reviewed the published and 'grey' literature on particular topics. After discussion in Brussels in November 2000 the papers were published by the Institute of Tropical Medicine in book form, and over 4,000 copies of the book have been distributed. Now these papers are available on a CD-ROM, which has been funded by the UK Department for International Development (DFID). Requests for copies to info@jsiuk.com and indicate the number of CD-ROMS requested.]

Breastfeeding Committee for Canada (BCC) (Luisa Ciofani of AWHONN Canada).

BCC's revised and updated website is at http://www.breastfeedingcanada.ca . New information has been added including listings of BCC committees with their chairs and terms of reference, and a list of the representatives of provinces and territories who sit on the BCC's P/T Committee.

The BCC's Baby Friendly Initiative Practice Outcome Indicators for Hospital and Community Health Services are now available on the BCC website. The indicators have been developed to provide clarification on expectations at assessment for Baby Friendly designation in both: hospitals - maternity services, and community - public health services. They are based on the international WHO/UNICEF Baby Friendly Hospital Initiative Global Criteria and the BCC's Baby Friendly in Community Health Services Implementation Guide. They will be of great assistance to groups who are working on implementing the Ten Steps for Hospitals or Seven Points for Community Health Services.

Health Canada has issued revised draft statements on *Exclusive Breastfeeding Duration* and *Vitamin D for Breastfed Infants*. These are updates of the original recommendations made in the 1998 Canadian document *Nutrition for Health Term Infants* (http://www.hc-sc.gc.ca/dca-dea/prenatal/nutrition_e.html).

If you are not currently a BCC associate member and wish to be, simply send a cheque or money order for $10 payable to the Breastfeeding Committee for Canada to the following address: Breastfeeding Committee for Canada, P.O. Box 65114,Toronto, ON, M4K 3Z2 .

A Book Review

The book by Colapinto, J. (2000). *As Nature Made Him*, was reviewed in the March 2001 AMNL Newsletter No. 17, pages 13-14. The book tells about twin boys born in Winnipeg on August 22, 1965. The paediatrician advised that they be circumcised and an inexperienced doctor burnt the penis off the first baby. The sexologist, John Money, was conducting research at Johns Hopkins Hospital on gender reassignment. He tried to change Bruce, the damaged boy, into a girl by using castration and hormones. The experiment was not successful and Brenda the "girl" encountered many problems, as did his brother and parents. His brother felt neglected in favour of his "sister" and his parents were blamed for the failure of the experiment. He changed back to his original gender in August 1980. He became David, and had to receive hormone treatment and surgery over the next five years. In 1990 he married a woman and adopted her three children. John Money continued with his experiments, even though he was removed from his office at the university, especially recruiting boys who had been damaged by circumcision.

An update on this sad story. The May 13, 2004, *Daily Telegraph* had an obituary for "David Reimer. Guinea pig in a notorious experiment in the 1960s and 1970s to prove the power

of nurture over nature" (p. 27). David committed suicide on May 4, 2004. His marriage had failed and in 2002 his twin brother had died from a drug overdose.
Note: The Canadian Paediatric Society (www.cps.ca) has a position statement on circumcision stating that the benefits and harm of circumcision are evenly balanced. The incidence rate of the complications of circumcision reported in published articles varies, but it is generally in the order of 0.2% to 2.0%.

Have You Read?
Midwifery and Related Topics

- Beyea, S. C., Kobokovich, L. J., Becker, S. C., & Hicks, R. W. (2004). Medication errors in the LDRP. Identifying common errors through MEDMARX reporting. *AWHONN Lifelines, 8*(2), 130-140. [Medication errors are perhaps the most common type of error occurring in health care settings; the effects of these types of errors span the gamut from no harm to death. Discussion of a medication error leads to a better understanding of the causes and contributing factors, and future prevention. Few researchers have focused on the specific problems with medication errors occurring in labour, delivery and recovery (LDR), obstetrical recovery (OBR), and postpartum maternity units (MU). Slightly more than half of the errors originated in LDR and OBR. "Omission" and "improper dose/quantity" were the most commonly seen error types reported in LDR and in OBR. "Omission" and "unauthorized drug" errors were most common in the MU. The largest portion of errors occurred because the person involved had the requisite knowledge and skills but failed to safely perform the duty. Rule violation, such as not following established policies and procedures, was the second most commonly reported cause of error. Reported situational factors included distractions and workload increase. Organizational factors included shift change, floating staff, inexperienced staff, insufficient staff. The LDR had the most "harmful" errors and MU the least. Numerous errors occurred around the prophylaxis for GBS. Each clinical setting experienced errors involving misprogrammed infusion pumps, mislabeled IV solutions, disconnected or misconnected IV tubing, and errors in what solutions ended up being infused during an emergency. The products mostly involved in these instances were oxytocin and magnesium sulfate. Clearly labeled IV solutions, tubings and connections, with a unique labeling system would identify the solution being infused, and other recommendations are given. Also see www.ismp-canada.org (Institute for Safe Medication Practices Canada.]
- British Columbia Centre of Excellence for Women's Health. (2004). *Solving the maternity care crisis. Making way for midwifery's contribution.* Vancouver: Author.
- Clinical Issues. (2004). Leadership. *JOGNN, 33*(3), 354-387. [Includes 5 articles.]
- Edwards, N. (2004). Mary Uprichard lecture. Protecting, regulations and standards: Enabling or disabling? *RCM Midwives Journal, 7*(4), 160-163. [The less women felt that practitioners would protect their deepest concerns, the less safe they felt, and the more cautious and silent they became. The ultimate silence is unattended birth. It is known that women who hold strong views are most likely to receive the opposite of what they want, and that women with birth plans that request few interventions, receive more than similar women without birth plans.]
- Gould, D., Lupton, B., Marks, M., & Wales, N. (2004). Outcomes of an alongside birth centre in a tertiary referral centre. *RCM Midwives Journal, 7*(6), 252-256. [The birth centre is situated two floors below the main labour ward, there are no doctors present

although they can be summoned easily, via telephone if required. The midwives have all been taught obstetric emergency drills and procedures. The emphasis in the Birth Centre is on promoting normality and there are no facilities for continuous electronic fetal monitoring or epidural anaesthesia. Women who require fetal monitoring, request epidural, or develop complications, are transferred to the labour ward via a connecting elevator. Due to the highly-medicalised nature of the unit they have had to audit their outcomes closely and been subjected to more scrutiny than traditional labour ward areas.]

- Midwifery News. (2004). Quebec government approves hospital birth. *Canadian Nurse, 100*(4), 17. [Under an agreement announced by the Quebec provincial government in February midwives have gained access to hospitals. In the past midwives were only permitted to practise in birthing centres. It is hoped that this change will help to alleviate health human resources shortages within Quebec. An estimated 450 midwives practise in Alberta, British Columbia, Manitoba, Ontario and Quebec. Legislation has been passed but not yet implemented in Saskatchewan, and is about to be implemented in the Northwest Territories. Kim Campbell estimates midwives are presiding at some seven to 10% of births in regions where they practise - with waiting lists for their services virtually everywhere.]
- Paeglis, C. (2004). The RCM involvement with NICE guidelines. *RCM Midwives Journal, 7*(4), 150-151. [The National Institute for Clinical Excellence (NICE) publishes maternity-related clinical guidelines. It funds the Confidential Enquiries which can be obtained from www.cemach.org.uk. All completed guidelines are on the web site www.nice.org.uk.]
- Pollock, L. (2004). Communicating from a silent world. *RCM Midwives Journal, 7*(4), 144. [Deafness is an often neglected issue. But for the UK's midwives it is not one that they can afford to overlook. The Royal National Institute for the Deaf estimates that the National Health Service is wasting £20 million each year due to a lack of deaf awareness.]
- Students lose fight for maternity pay. (2004). *RCM Midwives Journal, 7*(5), 182. [Three student midwives are considering an appeal after losing their legal battle for maternity pay, because as trainees they were not protected by European directives. The present bursary scheme allows for 60 days sick leave but stops payment if a student takes maternity leave. The non-means-tested flat rate bursary of £10,000.00 is considered vital to attract students into the profession and retain them during their training, especially as the UK is presently short of 10,000 midwives.]

<u>Pregnancy</u>

- Abbott, L. (2004). Ectopic pregnancy: A real issue for midwives. *RCM Midwives Journal, 7*(6), 262-263. [Ectopic pregnancy is the third biggest killer of pregnant women in the UK, after thromboembolism and hypertensive disorders. Women die from ectopic pregnancy because of failure to suspect it and consequently substandard care is given. The majority of women who died had sought advice from a doctor with regards to their symptoms prior to death. Among the common causes of ectopic pregnancy are damage to the fallopian tube from previous infection or previous surgery, including caesarean section.]

- Cockey, C. D. (2004). Blood substances may predict pre-eclampsia. *AWHONN Lifelines, 8*(2), 107-109. [Abnormal levels of two molecules found in the blood appear to predict the development of preeclampsia. Women with elevated blood levels of soluble fms-like tyrosine kinase 1 (sFlt-1) later developed the condition. They also had lower levels of placental growth factor (PIGF) and vascular endothelial growth factor (VEGF) than did women who did not develop preeclampsia. In women with preeclampsia, sFlt-1 began to increase about five weeks before they developed the condition. Similarly, the women who developed preeclampsia had lower PIGF levels beginning in the 13th to 16th week of their pregnancies and lower VEGF levels during and shortly before preeclampsia.]
- Frias, A. E., & Belfort, M. A. (2004). Post Magpie: How should we be managing severe preeclampsia? *MIDIRS Midwifery Digest, 14*(1), 49-55. [From 2003, *Current Opinion in Obstetrics & Gynecology, 15*(6), 489-495. The international placebo-controlled Magnesium Sulphate for Prevention of Eclampsia (MAGPIE) trial was carried out in 33 countries to evaluate the efficacy of magnesium sulfate in decreasing the risk of eclampsia. A randomized trial enrolled 10,141 women. Hypertensive disorders of pregnancy are either those conditions that predate pregnancy, or those that develop during pregnancy, and these are explained and a table is included. Of the 1560 women who were randomized in countries with low perinatal mortality there were no maternal deaths, which was a contrast to countries with high perinatal mortality. The conclusion is that treatment of all patients with severe preeclampsia should include aggressive control of blood pressure with anti hypertensive drugs, close attention to fluid management, and magnesium sulfate prophylaxis. All patients with severe preeclampsia greater than 32-34 weeks' gestation should be delivered without delay. Patients with a gestational age less than 34 weeks should receive corticosteroids if both the maternal condition is stable and the fetal status is reassuring. Expectant management of severe preeclampsia at gestational ages of 24-34 weeks' gestation should only be considered if both the maternal and fetal conditions are stable and the appropriate resources for maternal and fetal antenatal surveillance and aggressive treatments are available.]
- Johnson, et al. (2004). Prevalence of smoking associated with pregnancy in three southern Ontario health units. *Canadian Journal of Public Health, 95*(3), 209-213. [The Ontario Tobacco Strategy goal of eliminating smoking in pregnancy has not yet been realized. Attention needs to be paid to the needs of women who are Canadian-born, have lower educational attainment, and are under the age of 25.]
- Lee, B. (2004). Domestic violence in pregnancy: Opening Pandora's box. *RCM Midwives Journal, 7*(4), 164-167. [Report of a meeting of the Forum on Maternity and the Newborn of the RSOM, November 13, 2003. A London study found that women with a history of domestic violence were significantly more likely to be single, separated, or in non-cohabiting relationships, to have smoked during the present pregnancy or in the year prior to pregnancy, and were more likely to have consulted their GP with 'nerves, anxiety, sleeping problems or feeling sad.' Higher scores on the EPDS were significantly associated with domestic violence, being single, separated or in a non-cohabiting relationship, and with obstetric complications. Those who had experienced domestic violence during pregnancy identified that trust in the midwife was a vital component of the woman-midwife relationship in order to facilitate discussion and disclosure. It is recommended that the introduction of routine enquiry is accompanied by an educational programme for professionals and that appropriate screening tools are developed. Gentle

and non-threatening direct questioning should be employed, since hedging around the issue will confer a sense of shame. Questioning should be conducted in a safe, confidential environment by a trained health professional. This report appears in full, with references, on www.motherhood.org.uk.]

- New report warns of smoking hazards for pregnant women. (2004). *RCM Midwives Journal, 7*(3), 98. [From the BMA Board of Science and Education and Tobacco Control Resource Centre. Smoking causes thousands of miscarriages and cases of cervical cancer in women and impotence in more than 200,000 young men. The British Medical Association advises that smokers should stop when trying for a baby, and fully paid leave for pregnant women whose employers cannot guarantee a smoke free zone. The report summarises the impact of active and passive smoking on sexual health, conception, pregnancy, the reproductive system, and infant and child health.]
- Peters, R. M., & Flack, J. M. (2004). Hypertension disorders of pregnancy. *JOGNN, 33*(2), 209-220. (Hypertensive disorders occur in 6% to 8% of all pregnancies. There has been controversy about how to measure blood pressure (b/p). The woman should be seated and her arm at heart level, using an appropriate-sized cuff. It is no longer recommended to measure b/p with a woman lying on her left side. In that position, the cuff is higher than the left ventricle, resulting in reduced hydrostatic pressure. This gives an inaccurately low reading, often reduced by as much as 10 to 14 mm Hg. A Table shows the classification of hypertension. The National High Blood Pressure Education Program advocates discarding the term *pregnancy-induced hypertension* because it does not differentiate between gestational hypertension, a relatively benign disorder, and the more serious preeclampsia. *Preeclampsia-eclampsia* is a pregnancy systemic syndrome with both maternal and fetal manifestations. The diagnosis of preeclampsia is determined by the presence of hypertension, occurring after the 20th week of gestation, accompanied by proteinuria. Preeclampsia also may be diagnosed without proteinuria if there are other systemic symptoms. In an uncomplicated pregnancy there are a number of changes which occur. Peripheral resistance decreases by 25%, and there is a 50% rise in total blood volume by the end of the 2nd trimester, and cardiac output increases in the 1st trimester, peaking at 35% to 50% above nonpregnant values. The diastolic pressure drops to an average of 10 mm Hg below nonpregnant values by mid pregnancy. Women with preexisting hypertension tend to have even greater decreases in their b/p in early pregnancy, and their "normal" rise in the 3rd trimester may be misdiagnosed as preeclampsia. The pathophysiology of preeclampsia can be divided into two stages: alterations in placental perfusion (stage 1) and the maternal syndrome (stage 2). Placental hypoxemia is the proximate cause of preeclampsia. In Stage 2 the plasma volume is reduced, with decreased blood flow to organs other than the placenta resulting in haemoconcentration, haemorrhage, and necrosis. The coagulation system is activated in preeclampsia, and thrombocytopenia occurs. Organ changes include changes in the kidney, and the liver. Convulsions mark the eclamptic phase of preeclampsia and indicate central nervous system involvement. Seizures are no longer believed to result only from hypertensive encephalopathy. Many of the pathophysiological changes of preeclampsia occur before clinical symptoms are present. Edema is no longer included as a cardinal symptom of preeclampsia, as it occurs in many uncomplicated pregnancies. Studies found no evidence to support that prophylactic antihypertensives prevented preeclampsia or improved fetal outcomes. Delivery of the fetus and placenta is the only "cure" for

preeclampsia. Magnesium sulfate has been proven safer and more effective than diazepam or phenytoin in preventing seizures. Medication choices in pregnancy are limited because a number of the antihypertensives are embryotoxic, and there is a lack of extensive randomized clinical trials on which to base their use. Diuretics should not be used as a prophylactic for preeclamptic hypertension.]

Genetics

- Cohen, S. M. (2004). Factor V Leiden mutation in pregnancy. *JOGNN, 33*(3), 348-353. [Inherited thrombophilias are the leading cause of maternal thromboembolism and have been associated with increased risk of adverse pregnancy outcomes, including 2nd- and 3rd-trimester fetal loss, abruptio placentae, intrauterine growth restriction, and early-onset, severe preeclampsia. Resistance to activated protein C is caused by a single adenine-to-guanine point mutation that leads to the substitutions of arginine for glutamine at nucleotide 506 in the factor V gene. This mutation is known as factor V Leiden. The factor V Leiden molecules resist degradation to activated protein C. However, they retain their pro-coagulant activity, and thus, the link with the increased risk of venous thromboembolism (VTE). The mutation is inherited as an autosomal dominant trait. Therefore, all carriers of the defect are affected, albeit to differing degrees. Homozygous carriers are at significantly greater risk for VTE and adverse pregnancy outcome than heterozygous carriers. Estimated carrier rates for individuals with a personal or family history of thrombosis have ranged from 20% to 60%. Most pregnant women with the factor V Leiden mutation will not experience VTE, and not all will receive anticoagulant prophylaxis. Prior to conception, affected women and families should receive education regarding factor V Leiden mutation in pregnancy and genetic counseling should be offered. Pregnancy is an acquired risk factor, as it results in a state of relative hyper-coagulation. Increased resistance to activated protein C occurs normally in all pregnancies during the 2nd and 3rd trimesters. Breastfeeding should be encouraged in the mother who continues anticoagulation therapy through the postpartum period. Low molecular weight heparin does not pass into the breastmilk and can be given to nursing mothers safely. Discovery of the factor V Leiden mutation in 1993 has led to more informed management of thromboembolic events in pregnancy that were previously presumed to be idiopathic. See SOGC *Clinical Practice Guidelines, No. 95*, September 2000, Prevention and Treatment of Venous Thromboembolism (VTE) in obstetrics (www.sogc.org then click on guidelines in the left menu).]

Labour and Birth

- Bahl, R., Strachan, B., Murphy, D. J. (2004). Outcomes of subsequent pregnancy three years after previous operative delivery in the second stage of labour: Cohort study. *RCM Midwives Journal, 7*(3), 97. (From *British Medical Journal, 328*, 311-320.) [If women experienced an instrumental delivery the first time they were more likely to achieve a vaginal delivery for their second birth. Forty nine percent of the women achieved a further pregnancy at three years, but a third wish to avoid a further pregnancy. The authors cite the ACOG and suggest further training in instrumental vaginal delivery. The study wants more research of the choice that mothers have for subsequent deliveries.]
- Baby brain injury at birth linked to mode of delivery. (2004). *RCM Midwives Journal, 7*(4), 143. [Reported from the *Lancet, 363*(9412), 846-851.] [Of the 111 babies studied, nine babies had subdural haemorrhages, three (6%)were normal vaginal births, five (28%)

were delivered by forceps after an attempted ventouse delivery, and one (8%) had a traumatic ventouse delivery. No treatments were needed. A subsequent scan at four weeks of age showed complete resolution of the haematoma in all babies.]

- Grenfell Regional Health Services. (2004, March/April). *Along the Coast*. [This issue of the GRHS Newsletter includes information as"15-year veterans recount experiences with GRHS" (p. 14). One veteran is Samy Wilson, one of our AMNL members who is based in Charlottetown, Labrador. "Midwifery student teaches new birthing techniques" is an account of the stay of a midwifery student (Sarah Barillaro), in St. Anthony for one of her clinical placements. Sarah is from the midwifery program at McMaster University. The report shows her demonstrating the birthing ball. "The Birthing Ball is a physical therapy ball that is an essential comfort tool, used to help women into positions that help labor progress. For example, sitting on the ball encourages a natural swaying or rotating motion of the pelvis, promoting fetal descent. The ball provides perineal support without a lot of pressure and helps keep the fetus aligned in the pelvis. The sitting position assumed on the ball, similar to a squat, opens the pelvis, helping to speed up labor. Gently moving on the ball also greatly reduces the pain of contractions" (p. 22).]
- Dixon, L. (2004). Birth in a caul: A discussion on the role of amniotomy in physiological labour. *MIDIRS Midwifery Digest, 14*(1), 70-74. [The UK Amniotomy Group (1994), in a multicentre randomised trial of amniotomy, stated that beyond a modest shortening of labour, a policy of routine amniotomy has little effect on important outcomes and should not be recommended. In the latest update from the Cochrane Library (2001) it is suggested that amniotomy should be reserved for women with abnormal labour progress, as in a review of one large trial they found an increased rate of caesarean section following amniotomy. Midwives working in partnership with women should provide information to enable them to make choices. The information to date about amniotomy will probably lead to a decrease in this intervention and result in more births with intact membranes.]
- Fox, S. (2004). All-Wales clinical pathway for normal labour: A way to reducing unnecessary intervention? *RCM Midwives Journal, 7*(5), 216-219.
- Montagu, S., & Jowitt, M. (2004). NICE caesarean section guidelines. *ARM Midwifery Matters, No. 101*, 22-23. [The guidelines endorse the right of women to make choices on their care, but the framework adheres rigidly to the reliance on randomised controlled trials which consider treatments and not the individual woman and her caregiver.]
- Nick, J. M. (2004). Deep tendon reflexes, magnesium, and calcium: Assessments and implications. *JOGNN, 33*(2), 221-230. [Deep tendon reflexes are a powerful tool in determining the need to start, adjust, or stop magnesium infusion. Protocols for laboratory surveillance of serum magnesium levels are not consistent, and serum magnesium levels have limited diagnostic value. Literature on the neonatal benefits of using magnesium as a tocolytic provides conflicting evidence. Women receiving magnesium sulphate (MgSO4) are at risk for developing hypermagnesemia, so the normal, therapeutic, and toxic ranges of serum magnesium should be known. Calcium counteracts the effects of magnesium intoxication by simply undoing what magnesium has done. The higher the magnesium overload, the more calcium is required, but reversal is transient and repeated doses may be required. There is still a need for studies to answer questions about treatments and long-term effects on maternal and fetal health.]

- Slome, C.J. (2004). Perineal outcomes after practising with a perineal dilator. *MIDIRS Midwifery Digest, 14*(1), 37-41. [A descriptive, retrospective study aimed to evaluate the pros and cons of the use of a dilator bought by women in Israel. The findings were that there was a lower episiotomy rate, and the women reported increased confidence in their ability to birth. The majority of women also reported that it prepared them for the sensations of pushing and birth, even if they had to receive an episiotomy.]
- Society of Obstetricians and Gynaecologists of Canada. (2004, March 2). Media release. SOGC's position on elective C-sections. See web site: www.sogc.org.

Infections

- Boyer, S. G., & Boyer, K. M. (2004, June 16). Update on TORCH infection in the newborn infant. *Newborn and Infant Nursing Reviews, 4*(1). [www.medscape.com Medscape_nursing@mp.medscape.com]
- Schneider et al. (2004). SARS in pregnancy. This case study explores the first documented infection in the US. *AWHONN Lifelines, 8*(2), 122-128. [The pregnant woman had SARS, developed gestational diabetes and then had a full term baby delivered by cesarean section due to placenta previa. The team of professionals providing her care kept in contact with the CDC. The guidelines developed for her care were based on the evidence of prolonged shedding of SARS-CoV in the stool of convalescing patients. There is no evidence for perinatal transmission and it is unknown whether the shedding of SARS-CoV in human birth products occurs. What is known is that certain animal corona viruses are associated with fetal infection and demise. At this mother's delivery, maternal serum, cord blood and breastmilk all tested positive for corona virus. Blood EDTA, nasal pharyngeal swab, placental tissue and amniotic fluid all tested negative. Breastfeeding began as soon as possible after the birth, as it was decided that the benefits of breastfeeding would outweigh any of the possible risks.]

Neonatal Care

- Bulletin Board. (2004). Consumers warned not to feed infants Better Than Formula Ultra Infant Immune Booster 117. *AWHONN Lifelines, 8*(2), 152. [The FDA is warning that Better Than Formula Ultra Infant Immune Booster 117, sold over the Internet as a dietary supplement, should not be fed to infants. The labeling is misleading. The product would not support growth of infants, does not contain nutrients essential for infants, or been manufactured using good practices. The label lists a number of ingredients that have not been evaluated for safe use in infant formula.]
- Clinical Issues. (2004). Stress in the neonate. *JOGNN, 33*(2), 235-275. [Includes 5 articles.]
- Ford, L. (2004). Group B streptococcus. *AWHONN Lifelines, 8*(2), 102-103. [Group B streptococcus (GBS) is the most common single cause of sepsis in newborns in the first week of life, and is a leading bacterial cause of perinatal mortality and morbidity, affecting 15 to 40% of infants born in Canada. (The SOGC has guidelines for the detection, treatment and management of GBS in mothers and babies.) Based on the evidence collected, the practice of routine ear swabbing of babies born to mothers who test positive for GBS has been discontinued at the IWK, Halifax. This represents a saving of approximately $14,000 per year. Treatment is based on nurses' and parent's observation of the physical signs seen in symptomatic newborns. The nurses developed a comprehensive discharge education program so that families could recognize and identify early and late onset GBS illness in their newborns.]

- Harrison, J. (2004, Summer). In praise of real nappies. *ARM Midwifery Matters, no. 101*, 17. [Much information from the Women's Environmental Network Briefing www.wen.org (December 2000), wen.org.uk/nappies (2002), and www.theecologist.co.uk (March 22, 2001).]
- Medves, J. M., & O'Brien, B. (2004). The effect of bather and location of first bath on maintaining thermal stability in newborns. *JOGNN, 33*(2), 175-182. [In this Canadian study the thermal stability during the first bath of 111 newborns bathed by either maternal-child nurses in the newborn nursery or by the parents at the bedside, were compared. The results showed that there was no difference in temperature change. Heat loss experienced by newborns during bathing is significant and is not associated with who bathes the newborn or where the bath takes place.]
- Rusen, I. D., Shiliang, L., Sauve, R., Joseph, K. S., & Kramer, M. S. (2004). Sudden infant death syndrome in Canada: Trends in rates and risk factors, 1985-1998. *Chronic Diseases in Canada, 25*(1), 1-6. [In Canada SIDS remains the leading cause of post neonatal death. However, SIDS rates have been declining in many countries, including Canada. This decline has been largely attributed to recommendations to avoid placing infants to sleep in the prone position.]

<u>Breastfeeding</u>

- Daneault, S., Beaudry, M., & Godin, G. (2004). Psychosocial determinants of the intention of nurses and dietitians to recommend breastfeeding. *Canadian Journal of Public Health, 95*(2), 151-154. [To improve recommending breastfeeding in New Brunswick, a strategy should consider including the following aspects: improve the availability of community and professional resources for breastfeeding as well as social support for mothers who wish to breastfeed; improve the ability of health professionals to overcome perceived barriers when recommending breastfeeding, by developing activities to improve knowledge and clinical skills in breastfeeding management; offering opportunities to exchange information with others on their experiences and on their role with breastfeeding protection, promotion and support; professional organizations for nurses and dietitians should clearly state their members' roles and responsibilities towards breastfeeding . Policy statements supporting breastfeeding should be adequately disseminated.]

<u>Women's Health</u>

- Joseph, S., & Bailham, D. (2004). Traumatic childbirth: What we know and what we can do. *RCM Midwives Journal, 7*(6), 258-261. [In 1994 the American Psychiatric Association changed their description of what constitutes a necessary traumatic event for the diagnosis of post-traumatic stress disorder (PTSD) to "an event in which the person witnessed or confronted serious physical threat or injury to themselves or others and in which the person responded with feelings of fear, helplessness or horror". The term childbirth-related PTSD is a broad term encompassing a variety of experiences and the intention is not to imply that giving birth is a traumatic experience. Also, postpartum depression is not PTSD. Some women may have PTSD that predates the labour, for example have a history of sexual abuse or rape. But, some women have developed PTSD in response to childbirth-related trauma. Research is needed to understand more about therapeutic interventions.]

Research and Methods

- Sakala, C. (2004). Resources for evidence-based practice, March/April 2004. *JOGNN, 33*(2), 231-234. [Cochrane Database of Systematic Reviews (www.cochrane.org/reviews), Database of Abstracts of Reviews of Effects (DARE) (http://nhscrd.york.ac.uk), and other sites are explored.]
- Schnarch, B. (2004, January). Ownership, control, access, and possession (OCAP) or self-determination applied to research. A critical analysis of contemporary First Nations research and some options for First Nations communities. *Journal of Aboriginal Health,* pp. 80-95.
- Shields, B., & Knight, B. (2004). Improving the quality of maternity data: Lessons from the Exeter Family Study of Childhood Health. *RCM Midwives Journal, 7*(4), 156-159. [Midwives need to chart accurately, and typing in the data may result in errors. Small errors in a data set can have a large impact on statistics, and may drastically alter the results of the final analysis. There is a need for data 'cleaning' before using data.]
- Smylie, J. et al. (2004). Health sciences research and aboriginal communities: Pathway or pitfall? *Journal of Obstetrics & Gynaecology Canada, 26*(3), 211-216.
- van Teijlingen, E., & Cheyne, H. (2004). Ethics in midwifery research. *RCM Midwives Journal, 7*(5), 208-210. [There are four groups of people involved in most research projects. There are those who must know, those who should know, those who could know, and those who should not know. Ethical principles can help to clarify the judgments that have to be made while planning, conducting and reporting research. In the conduct of good research is the principle that "the dignity, rights, safety and wellbeing of participants must be the primary consideration". A researcher has the right to conduct research as a form of freedom, both of thought and expression. Academic freedom is important, but the researcher should question whether they can justify the research on moral grounds. The research should not be primarily for self promotion. Also, unethical studies can receive bad publicity and make future studies in the same field or area harder, as potential respondents will be more dubious about participating.]

Alternatives

- Weier, K. M., & Beal, M. W. (2004). Complementary therapies as adjuncts in the treatment of postpartum depression. *Journal Midwifery Womens Health, 49*(2), 96-103. [Also available on www.medscape.com/viewarticle/471895_print.]

Conferences As this information comes from a variety of sources the editor takes no responsibility for any errors.

2004

July 22-23, 2004. "The Midwifery Way: A National Forum Reflecting on Midwifery Regulation in Canada". Halifax, Nova Scotia.
Contact: Christine Saulnier, Atlantic Centre of Excellence for Women's Health. P. O. Box 3070 Halifax, N.S. B3J 3G9 (Telephone: (902)470-6752; toll free 1-888-658-1112; E-mail: christine.saulnier@dal.ca; Web site http://www.acewh.dal.ca)

August 1-7, 2004. World Breastfeeding week. "Exclusive breastfeeding: The gold standard - safe, sound and sustainable."

September 30 - October 1, 2004. "Promoting Maternal Mental Health In Pregnancy", sponsored by the Atlantic Chapter of AWHONN Canada, Dartmouth, NS. Keynote speaker: Barbara Pfaff. Contact: see www.awhonn.org - pull down menu, quick links and section website, click on Canada.

October 1-7, 2004. Canada Breastfeeding week.

October 21-23, 2004. "Celebrating Diversity and Strength. The Fifth Canadian Rural Health Research Conference" and "The Fourth International Rural Nursing Congress", Sudbury, ON.
Cost: Early registration before September 1.
Contact: Donna Bentham (Telephone: 250-960-6409; E-mail: rrn@unbc.ca; Web site for Canadian Rural Health Research Society http://crhrs-scrsr.usask.ca/sudbury2004)

October 13, 2004. ARNNL 50th anniversary meeting

November 11-13, 2004. "Honouring our past, Embracing the present, Redesigning our future", AWHONN Canada 15th National Conference, Regina.
Contact: Susan Mussell, St. Boniface Hospital, D2045-409 Tache Avenue, Winnipeg, MB, R2H 2A6 (Fax: 204-233-1751; E-mail: smussell@sbgh.mb.ca).

Snippets from the UK News - from the *Daily Telegraph*, May 2004.

A paediatric neurologist who works at a Virginia hospital in the USA, also works at Stork Studios in Washington, DC, where mothers go to obtain "portraits" and videos of their unborn baby. The standard package costs the equivalent of £125. (£1 = approx. $2.50 Can). The "Keepsake Ultrasound" businesses operate in a legal grey zone. The healthy babies the doctor sees at Stork Studios are "a happy counter-balance" to the sick babies seen on hospital ultrasounds. The doctor is confident that these ultrasounds are good as they provide "parental bonding". The US Federal Drug Administration has condemned "Keepsake Ultrasounds" as "inappropriate and contrary to responsible medical practice". Scientists do not know "the long-term effects of repeated ultrasound exposures on the fetus" (May 18, p. 15).

A study has found that one in seven cases of schizophrenia may be caused by influenza during pregnancy, especially in the first trimester. This may account for 14% of schizophrenia cases. Some researchers believe that either the high body temperature, or a surge of cytokines released by the immune system to fight the infection, may be responsible. Giving influenza immunization to women of childbearing age is recommended (May 16, p. 11).

An unmarried mother was jailed for two years after offering her unborn baby to three childless couples, over the Surromomsonline web page. She accepted £6,000 from two couples, then cancelled these agreements after entering into a new agreement with a third couple for £8,000. For a time the three couples thought that they were all going to adopt the baby. DNA tests subsequently revealed that none of the three men was the baby girl's father. She was arrested after giving birth and the baby was taken by the Social Services. Eighteen months earlier the mother had "sold" a son to another couple through the surrogate agency COTS. In 2003 she had also donated 12 eggs to a clinic. She has a six-year-old son who is autistic. The judge accused her of cheating her victims and undermining the regulation of the adoption process (May 22, p. 8).

A baby girl died after her parents refused to let midwives help with a natural home birth. This was a breech birth and the head became stuck. She died four days later when her ventilator was turned off. After being admitted to the hospital the mother was found to have been pregnant with twins, and the second baby was born by emergency caesarian section. The coroner said that it was a "sad nature of society" that interference by midwives without consent could be interpreted as assault. The parents knew that the baby was presenting as a breech and of the possible dangers and difficulties. When the mother went into labour she refused to let the midwives listen to the baby's heart, to palpate her abdomen, or to have any light except candles in the cold room. The head was stuck for 24 minutes during which time the baby lacked oxygen and lost heat. The parents then would not let the midwives try to resuscitate the baby for a further four minutes. The Crown Prosecutor found no "breach of negligence or duty" on the part of the midwives. The National Childbirth Trust said that "midwives should not intervene against mothers' wishes unless there is a good clinical reason to do so" (April 22).

A four year old, who is severely disabled, was denied compensation after a judge ruled it was impossible for maternity units to guarantee a safe birth. "Obstetrics could never be entirely risk free. This case provides a tragic example of how, even in the 21st century, labour remains an entirely unpredictable and potentially hazardous event". When the child was born the obstetrician and registrar (resident) were attending a woman with life threatening complications. (Mother and baby fully recovered). The senior midwife then faced a "rapidly escalating and acute emergency" and had to cope with the breech birth without the help of doctors because of the "rare event of a competing medical emergency occurring simultaneously in the unit". This case contrasts with recent huge payments to other families who claimed medical negligence in maternity cases (May 22, p. 8).

Tiny particles (PM10) from vehicle exhaust fumes have been linked with 16% of unexplained deaths among babies of normal weight. Sudden infant death syndrome (SIDS) affects about 300 babies a year in Britain. Particulate air pollution can cause genetic mutations which can be passed on to future generations (May 18, p. 11).

In a new campaign against methicillin resistant staphylococcus aureus (MRSA) patients are being encouraged to ask all hospital staff if they have washed their hands. The MRSA, and other germs are thought to cost the National Health Service about £1 billion per year and contribute to the death of 5,000 patients annually. Cleaners contracted to clean hospitals should not be paid unless the job is done properly. A number of young, new nurses are said to be "too posh to wash" their patients (May 16, p. 5).

In 1999 the National Institute for Clinical Excellence (NICE) was established to supply evidence-based advice to the health service. At the beginning of May the *Lancet* reported on a study regarding the NICE recommendations for wisdom tooth extraction and hip replacements. They found that doctors continued with their usual practice. This is similar to the experience of physician, Ignaz Semmelweis, who in 1840 reduced "the death rate on maternity wards from 20% to zero by demanding that doctors wash their hands in disinfectant before carrying out examinations. He was rewarded with the sack, after which the death rate shot back up and stayed there for years". In 1747 the physician James Lind, began a simple clinical trial by dividing sailors sick with scurvy into pairs and giving each pair one of the remedies in use at that time. The pair given a daily ration of oranges and lemons recovered. "The Admiralty's medical experts remained unimpressed, however, and it took another 50 years for citrus fruit rations to become routine in the Royal Navy". (Vitamin C was not identified until 1932) (May 16, p. 33).

Hospitals are being urged to return to Florence Nightingale's 1857 traditional standards and make sure that patients eat their meals when they are in a hospital. This is to counter the known problem of malnutrition in hospitals. Research has shown that 40% of hospital patients are malnourished on admission and of these, 70% become further malnourished in their first week in a hospital. Patients are not helped into comfortable eating positions, food is left out of reach and often placed on bedside tables next to vomit bowls. King's College Hospital closes wards to all but essential visitors between noon and 2:00 p.m. so that meal times are not interrupted by doctors, therapists and visitors (May 13, p. 12).

Too much time spent sun bathing can result in age-related maculopathy starting before age 40 years (May 16, p. 11).

Now that pets can travel with a pet passport, a growing number of British pets are catching deadly diseases when taken to southern Europe. Leishmaniasis from sand flies, babesiosis and ehrlichiosis spread by ticks, and heart worm spread by mosquitoes, are incurable and the animal dies within days or years. The School of Tropical Medicine treats humans but works closely with Liverpool University's veterinary department and has set up Testapet to help vets who are seeing animals with these diseases not usually found in Britain (May 16, p. 15).

Mother defends right to birth of her choice By Celia Hall (Filed: 13/11/2003)

Dawn James says that forcing a woman to go through the pain of childbirth in this day and age is nothing short of medieval. Her son Thomas was born 14 weeks ago at the Chelsea and Westminster Hospital in London by caesarean section for no other reason than she requested it, she said. Mrs James did not want to put herself through a natural childbirth. "I was perfectly healthy but I wanted a caesarean and I would not be talked out of it," she said. Thomas was a healthy 8 lb baby at birth and Mrs James, 37, was up and about the next day. The following week she took her dogs for a walk in the park."As soon as I knew I was pregnant, I told my GP I didn't want to go through natural childbirth," she said. "My mother was a midwife, I had done my research, spoken to a lot of people. I knew the pros and cons on both sides of the argument." Mrs James, a management consultant from south-west London, opted to have her baby at the Chelsea and Westminster because it is her nearest hospital and her GP said they had a policy of allowing women to choose. "There is a group of women who have this attitude that it is macho to go through the pain of childbirth. Why should I have to do that? I would not walk the streets of London with a screaming headache and not take a painkiller. "I feel very strongly that people or organisations who seek to make women feel guilty about not going through childbirth in a natural manner are evil." She said that as a taxpayer she should be able to choose how to have a baby on the NHS. "My husband and I pay more in taxes every year than the salary of a consultant obstetrician. We pay the doctors' wages," she said. Mrs James said that if she had not been allowed a caesarean on the NHS she would have paid £8,000 to have her baby at a private hospital. A spokesman for Chelsea and Westminster Healthcare NHS Trust said: "If a woman is keen to have a caesarean, this choice is considered against a range of factors including clinical and psychological, and we explain the risks for the mother and baby."

Congratulations to Kelly Monaghan and family.

April 27, 2004. Baby girl Aoife (ee-fah) was born 6:29 a.m. She weighed in at 7lbs 12-and-a half ounces. The family was present at the home birth with midwife Karen Robb and doula Rhonda Taylor. The family doctor sat back and watched. (Photos of the birth were shown on CBC national channel (20 in St. John's), and Kelly, Aoife, and Karen were interviewed on the local TV Channel 9).

High Court Appeal Needed to Protect EI Benefits. (2004, March). *CAUT Bulletin, 51*(3), A3, A4. Barbara Cameron is an associate professor of political science in the Atkinson School of Social Sciences at York University and is a member of CAUT's Status of Women committee.

The Quebec Court of Appeal ruled Jan. 27, 2004 that maternity and parental leave provisions fall within the jurisdiction of provincial governments and exceed the exclusive federal jurisdiction over employment insurance. On Feb. 23, after intensive lobbying by labour and women's organizations, the federal government filed an appeal of the decision to the Supreme Court of Canada. That appeal was strongly opposed by Quebec organizations, and just as strongly supported by those from the rest of Canada. The case originated in a dispute between the federal and Quebec governments around section 69(2) of the Employment Insurance Act which provides a kind of opting-out with compensation for provinces that have programs that replace in whole or in part the types of benefits (maternity/parental, sickness, injury and others) offered under federal legislation. The opting-out takes the form of a reduction in premiums paid by employers and employees, which the province can recoup for its own benefits program. The special benefits at the centre of the dispute concerned maternity and parental leave provisions of the EI program. The mechanism provided for in this section will be familiar to union members who were active in 1971 when sickness and pregnancy benefits were first introduced into the Unemployment Insurance Act. At that time, the federal government wanted to encourage employers who already had such plans in place to retain them. It therefore provided for a reduction in employer and employee contributions in a section that is now 69(1). Rather than simply reduce the premiums, the reduction takes the form of a rebate that goes to an employer to be applied to some project or activity the employer and employees mutually determine. In the case of my university, the rebate results in a $50,000 annual contribution to the York University Faculty Association Trust, which in turn helps fund the faculty club.

Under pressure from a coalition of labour, community and women's organizations, then premier Lucien Bouchard announced in 1996 that Quebec would make use of this provision in the EI Act to help put in place a provincial program of parental leave. An initial round of negotiations took place in the wake of the near federalist defeat in the 1995 Referendum, at a time when Parliament was passing resolutions recognizing Quebec as a distinct society and approving the federal withdrawal from training and housing. At this time, the federal position, as communicated by the Human Resources Development Ministry, was that Quebec could opt out of the federal program entirely in order to create a parental leave program fully integrated with the rest of its family policy, which included $5-a-day child care. Negotiations broke down over the formula for calculating the premium reduction, not over the principle.

Quebec attempted to restart negotiations after the federal government extended parental benefits to 35 weeks in 2000. From the correspondence between the two governments submitted to the Quebec Court of Appeal by the provincial government, it appears Jane Stewart, then HRDC Minister, did not even respond to letters from Quebec ministers between February 2000 and October 2001. When she did respond, it was to articulate an entirely new position - that Quebec's parental leave program should take the form of a top-up and supplement to the federal program. In frustration over its inability to restart negotiations, Quebec turned to the court for a decision on the constitutionality of the federal government's maternity and parental leave benefits under the EI Act. The Quebec Court of Appeal ruling is an odd one, containing giant leaps of legal reasoning and outdated notions of women's role in the labour force. On reading the decision, it is hard not to feel irritated with both the federal and Quebec governments. In a game of jurisdictional chicken, one government was prepared to put at risk an essential component of the very progressive Quebec family policy and the other the maternity and parental benefits within EI that labour and women's organizations fought for over many decades.

The Quebec decision is advisory and does not strike down the federal law; that would require a separate legal case challenging the provisions of the law. If that were to happen, the Quebec Court of Appeal ruling would be treated as a precedent in Quebec and courts in the rest of Canada would be free decision does not prevent negotiations between Quebec and the federal government under section 69(2) of the current Act and these are already underway. However, an appeal to the Supreme Court is necessary to confirm the scope of federal jurisdiction and to ensure politicians do not use the Quebec ruling to weaken or prevent improvements to the maternity and parental provisions in the EI Act.

ITEMS REQUIRED BY THE END OF AUGUST FOR THE SEPTEMBER NEWSLETTER.
HAVE AN ENJOYABLE SUMMER.

ASSOCIATION OF MIDWIVES OF NEWFOUNDLAND and LABRADOR
APPLICATION FOR MEMBERSHIP
2004

Name: _____
(Print) (Surname) (First Name)

All Qualifications: _____

Full Address: _____

_____

Postal code: _____ Telephone No. _____
(home)

Telephone No. _____ Fax No. _____
(work)

E-mail Address: _____

Work Address: _____

_____

Area where working: _____

Retired: _____ Student: _____ Unemployed: _____

List of Organizations of which you are a member (the Association receives requests from various organizations for representatives to review articles, attend conferences, be on committees). Your name would not be forwarded without your consent.

Provincial: _____

National: _____

International: _____

Would be interested in participating in a research project if asked: Yes ____ No _____

I agree to my address, postal and Internet, to be released to CAM: Yes ____ No _____

If already pay CAM fees as a **Full** member of another Canadian Midwives Association, name of Association:

_____

I wish to be a member of the Midwives Association and I enclose a cheque/money order from the post office

for: $_____
(Cheques/money orders only (no cash) made payable to the Association of Midwives of Newfoundland and Labrador).
Full membership for **ALL** midwives is **$75.00** (as this includes the Canadian Association of Midwives fees which the Association has to pay).
Associate membership for those who are not midwives is **$40.00**
Membership for those who are unemployed/retired is **$20.00**
Membership for those who are residing outside of Canada **$85.00** (to cover the cost of the extra postage).

Signed: _____ Date: _____

Return to: Pamela Browne, Treasurer, Box 1028, Stn. C, HVGB, Labrador, NL, A0P 1C0